STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 00 B. WING	12/29/2014

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SOUTH SHORE HEALTH & REHABILITATION CENTER	353 TYLER ST GARY, IN 46402

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F000000	This visit was for the Investigation of Complaint IN00161017. Complaint IN00161017- Substantiated. Federal/State deficiencies related to the allegations are cited at F-157, F-225, and F-226. Survey date: December 29, 2014 Facility number: 000369 Provider number: 155530 AIM number: 100275190 Survey team: Janet Adams, RN-TC Census bed type: SNF/NF: 67 Total: 67 Census payor type: Medicare: 7 Medicaid: 57 Other: 3 Total: 67 Sample: 3 These deficiencies reflect State findings cited in accordance with 410 IAC	F000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	16.2-3.1. Quality review completed on December 29, 2014, by Janelyn Kulik, RN.			
F000157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.			

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	The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview, the facility failed to ensure the Physician was notified of a new onset of leg swelling, redness and complaints of pain for 1 of 3 residents reviewed for injuries in the sample of 3. (Resident #C) Findings include: The closed record for Resident #C was reviewed on 12/29/14 at 9:30 a.m. The resident's diagnoses included, but were not limited to, dementia, high blood pressure, and coccyx wounds. The 12/2014 Physician orders were reviewed. There was an order written on 12/7/14 at 8:00 a.m. for X-rays of the resident's tibia, fibula, foot, and ankle to be completed. The 12/2014 Nursing Progress Notes were reviewed. An entry made on 12/6/14 at 2:00 a.m. indicated the resident was resting quietly in bed and responded to verbal and tactile stimuli. The entry also indicated the resident voiced no complaints of pain and was in no acute distress. The next entry was made on 12/6/14 at	F000157	The facility will notify physician of changes in condition of residents who are dependent or have injuries of unknown origin Resident #C's chart has been reviewed to ensure that notification occurred Follow up was completed No new issues noted The 24-hour reports have been reviewed for the past 30 days to identify any other changes in condition or injuries of unknown origin for dependent residents No new issues identified Nurses will be in-serviced on identifying issues of unknown origin, ensuring that the 24-hour report is updated and that incident reports are completed, with investigations. DON or designee will monitor 24-hour reports and incident reports at least 3 times a week to ensure compliance Results of audits will be reported to QA for 6 months or until problem is considered resolved Problem will be considered resolved if no new issues are noted after 3 months of auditing Request Paper Compliance.	01/20/2015

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	5:00 p.m. This entry indicated the resident was asleep in the easy chair and complained of pain in the right leg. Right foot and ankle swelling were noted and Vicodan (a narcotic pain medication) was administered. The Physician was paged with no return call and staff would continue to monitor and render total care for the resident. The next entry was made on 12/7/14 at 5:30 a.m. This entry indicated the resident complained of foot pain and her right foot and ankle were swollen. The scheduled Tylenol # 3 (a narcotic pain medication) was given and staff would continue to monitor the resident. There was no documentation of the Physician being notified of the continued leg redness, swelling, and pain. The next entry was made on 12/7/14 at 8:00 a.m. This entry indicated the Radiology Service was called to obtain an X-ray of the resident's foot, ankle, and right tibula [SIC] and fibula (leg bones). When interviewed on 12/29/14 at 9:55 a.m., the Director of Nursing indicated the resident had first complained of pain on 12/6/14 at 5:00 p.m. and the Physician was paged and did not call back. The Director of Nursing indicated the next entry was made on 12/7/14 and there was			

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	no documentation of the Physician being notified of the resident's continued swelling, redness, and pain of the right leg until the order for X-rays were obtained on 12/7/14 at 8:00 a.m. The facility policy titled "Notification for Change in Resident Condition or Status" was reviewed on 12/29/14 at 12:20 p.m. There was no date on the policy. The Director of Nursing provided the policy and indicated the policy was current. The policy indicated facility staff were to promptly notify the Physician of changes in the resident's medical or mental condition or status. The Policy also indicated staff were to notify the attending Physician or the on-call Physician when injuries of an unknown source were discovered, a need to alter the resident's medical treatment significantly, or a change in the resident's physical/emotional/ or mental status. This Federal tag relates to Complaint IN00161017. 3.1-5(a)(2)			
F000225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who			

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	have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on record review and interview, the facility failed to ensure an injury of unknown origin for a cognitively impaired dependent resident was	F000225	The facility will notify physician of changes in condition of residents who are dependent or have injuries of unknown origin Resident #C's chart has been	01/20/2015

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	investigated in a timely manner for 1 of 3 residents reviewed for injuries in the sample of 3. (Resident #C). Findings include: The closed record for Resident #C was reviewed on 12/29/14 at 9:30 a.m. The resident's diagnoses included, but were not limited to, dementia, high blood pressure, and coccyx wounds. Review of the 11/09/2014 Minimum Data Set quarterly assessment indicated the resident's cognitive patterns for decision making were severely impaired. The assessment also indicated the resident was dependent on two or more staff members for bed mobility, transfers, and toilet use. The assessment indicated the resident was dependent on one staff member for dressing, eating, and personal hygiene. The assessment also indicated the resident rejected care daily and displayed physical behaviors directed towards others daily during the assessment reference period. The 12/2014 Physician orders were reviewed. There was an order written on 12/7/14 at 8:00 a.m. for X-rays of the resident's tibia, fibula, foot, and ankle to be completed.		reviewed to ensure that notification occurred Follow up was completed No new issues noted The 24-hour reports have been reviewed for the past 30 days to identify any other changes in condition or injuries of unknown origin for dependent residents No new issues identified Nurses will be in-serviced on identifying issues of unknown origin, ensuring that the 24-hour report is updated and that incident reports are completed, with investigations. DON or designee will monitor 24-hour reports and incident reports at least 3 times a week to ensure compliance Results of audits will be reported to QA for 6 months or until problem is considered resolved Problem will be considered resolved if no new issues are noted after 3 months of auditing Request Paper Compliance.	

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	The 12/2014 Nursing Progress Notes were reviewed. An entry made on 12/6/14 at 2:00 a.m. indicated the resident was resting quietly in bed and responded to verbal and tactile stimuli. The entry also indicated the resident voiced no complaints of pain and was in no acute distress. The next entry was made on 12/6/14 at 5:00 p.m. This entry indicated the resident was asleep in the easy chair and complained of pain in the right leg. Right foot and ankle swelling were noted and Vicodan (a narcotic pain medication) was administered. The Physician was paged with no return call and staff would continue to monitor and render total care for the resident. The next entry was made on 12/7/14 at 5:30 a.m. This entry indicated the resident complained of foot pain and her right foot and ankle were swollen. The scheduled Tylenol # 3 (a narcotic pain medication) was given and staff would continue to monitor the resident. There was no documentation of the Physician being notified of the continued leg redness, swelling, and pain. The next entry was made on 12/7/14 at 8:00 a.m. This entry indicated the Radiology Service was called to obtain			

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	an X-ray of the resident's foot, ankle, and right tibula [SIC] and fibula (leg bones). The next entry was made on 12/7/14 at 5:05 p.m. This entry indicated the resident had been in "terrible pain" in the right lower extremities. The entry also indicated X-rays had been performed at 11:20 a.m. and the results had not come in yet. An entry made on 12/8/14 at 2:00 a.m. indicated results of the X-rays to the right foot, leg, and ankle showed arthritic changes and no fractures at this time. An entry made on 12/8/14 at 6:15 p.m. indicated the Nurse called the hospital to check the status of the resident and the hospital indicated the resident had a hip fracture was going to be admitted to the hospital. An entry made on 12/8/14 at 7:00 p.m. indicated the resident was sent to the hospital Emergency Room 1:45 p.m. and was admitted to the hospital. The report of the 12/7/14 results of the right hip, femur, knee, tibia, fibula, ankle and foot X-rays was reviewed. The findings indicated there was some demineralization and degenerative arthritic changes with no definitive			

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	evidence of recent fracture or dislocation of the right hip and femur. The report also indicated the results of the right knee, tibia, fibula, and ankle revealed mild soft tissue swelling. When interviewed on 12/29/14 at 9:55 a.m., the Director of Nursing indicated the resident was admitted to the hospital on 12/8/14 with a diagnosis of a right hip fracture. The Director of Nursing indicated the facility called the hospital and was told the resident had a right hip fracture. The Director of Nursing indicated the resident did not have a fall at the facility prior to the pain and swelling of her foot. The Director of Nursing indicated she did not do an investigation of the resident's right foot/leg swelling, redness, and pain on 12/6/14 or 12/17/14. The Director of Nursing indicated after she was notified of the fracture on 12/8/14 she did talk to some of the staff to verify the resident did not have any falls. When interviewed on 12/29/14 at 10:50 a.m., the Director of Nursing indicated there had been no incident report and she had not been notified of the swelling and pain of the resident's right foot on 12/6/14 or 12/7/14. The Director of Nursing indicated when she spoke with staff Nurses and CNAs on Monday			

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	12/8/14 she asked them if the resident had any falls and they indicated she did not. The Director of Nursing indicated the resident required the assistance of two staff members for transfers. The Director of Nursing also indicated the resident had a history of fighting with staff with transfers and care. The Director of Nursing indicated she was not working on 12/6/14 (Saturday) or 12/7/14 (Sunday) and was not informed of the resident's new onset of leg pain, swelling and redness until 12/8/14. When interviewed on 12/29/14 at 12:15 p.m., the Director of Nursing indicated all injuries including bruises, skin tears or any injuries that could not be explained were to be investigated. When interviewed on 12/29/14 at 11:20 a.m., the Social Service Director indicated the resident did have behaviors and would be physically aggressive with staff when they were providing care for the resident. When interviewed on 12/29/14 at 12:40 p.m., the facility Administrator indicated all injuries of unknown origin were to be investigated. The Administrator indicated the facility should have investigated the resident's pain, swelling, and redness to the leg earlier when first			

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	noted by staff since the resident was dependent on staff for care and had a history of being aggressive with care. This Federal tag relates to Complaint IN00161017. 3.1-28(c)			
F000226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to follow their Abuse Policy related to not investing an injuries of unknown or origin for 1 of 3 residents reviewed for injuries in the sample of 3. (Resident #C) Findings include: The closed record for Resident #C was reviewed on 12/29/14 at 9:30 a.m. The resident's diagnoses included, but were not limited to, dementia, high blood pressure, and coccyx wounds. Review of the 11/09/2014 Minimum Data Set quarterly assessment indicated	F000226	The facility will notify physician of changes in condition of residents who are dependent or have injuries of unknown origin Resident #C's chart has been reviewed to ensure that notification occurred Follow up was completed No new issues noted The 24-hour reports have been reviewed for the past 30 days to identify any other changes in condition or injuries of unknown origin for dependent residents No new issues identified Nurses will be in-serviced on identifying issues of unknown origin, ensuring that the 24-hour report is updated and that incident reports are completed, with investigations. DON or designee will monitor	01/20/2015

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	the resident's cognitive patterns for decision making were severely impaired. The assessment also indicated the resident was dependent on two or more staff members for bed mobility, transfers, and toilet use. The assessment indicated the resident was dependent on one staff member for dressing, eating, and personal hygiene. The assessment also indicated the resident rejected care daily and displayed physical behaviors directed towards others daily during the assessment reference period. The 12/2014 Physician orders were reviewed. There was an order written on 12/7/14 at 8:00 a.m. for X-rays of the resident's tibia, fibula, foot, and ankle to be completed. The 12/2014 Nursing Progress Notes were reviewed. An entry made on 12/6/14 at 2:00 a.m. indicated the resident was resting quietly in bed and responded to verbal and tactile stimuli. The entry also indicated the resident voiced no complaints of pain and was in no acute distress. The next entry was made on 12/6/14 at 5:00 p.m. This entry indicated the resident was asleep in the easy chair and complained of pain in the right leg. Right foot and ankle swelling were noted		24-hour reports and incident reports at least 3 times a week to ensure compliance Results of audits will be reported to QA for 6 months or until problem is considered resolved Problem will be considered resolved if no new issues are noted after 3 months of auditing Request Paper Compliance.	

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	and Vicodan (a narcotic pain medication) was administered. The Physician was paged with no return call and staff would continue to monitor and render total care for the resident. The next entry was made on 12/7/14 at 5:30 a.m. This entry indicated the resident complained of foot pain and her right foot and ankle were swollen. The scheduled Tylenol # 3 (a narcotic pain medication) was given and staff would continue to monitor the resident. There was no documentation of the Physician being notified of the continued leg redness, swelling, and pain. The next entry was made on 12/7/14 at 8:00 a.m. This entry indicated the Radiology Service was called to obtain an X-ray of the resident's foot, ankle, and right tibula [SIC] and fibula (leg bones). The next entry was made on 12/7/14 at 5:05 p.m. This entry indicated the resident had been in "terrible pain" in the right lower extremities. The entry also indicated X-rays had been performed at 11:20 a.m. and the results had not come in yet. An entry made on 12/8/14 at 2:00 a.m. indicated results of the X-rays to the right foot, leg, and ankle showed arthritic			

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	changes and no fractures at this time. An entry made on 12/8/14 at 6:15 p.m. indicated the Nurse called the hospital to check the status of the resident and the hospital indicated the resident had a hip fracture was going to be admitted to the hospital. An entry made on 12/8/14 at 7:00 p.m. indicated the resident was sent to the hospital Emergency Room 1:45 p.m. and was admitted to the hospital. The report of the 12/7/14 results of the right hip, femur, knee, tibia, fibula, ankle and foot X-rays was reviewed. The findings indicated there was some demineralization and degenerative arthritic changes with no definitive evidence of recent fracture or dislocation of the right hip and femur. The report also indicated the results of the right knee, tibia, fibula, and ankle revealed mild soft tissue swelling. When interviewed on 12/29/14 at 9:55 a.m., the Director of Nursing indicated the resident was admitted to the hospital on 12/8/14 with a diagnosis of a right hip fracture. The Director of Nursing indicated the facility called the hospital and were told the resident had a right hip fracture. The Director of Nursing			

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	155530	A. BUILDING 00 B. WING	12/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE HEALTH & REHABILITATION CENTER	353 TYLER ST GARY, IN 46402

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	indicated the resident did not have a fall at the facility prior to the pain and swelling of her foot. The Director of Nursing indicated she did not do an investigation of the resident's right foot/leg swelling, redness, and pain on 12/6/14 or 12/17/14. The Director of Nursing indicated after she was notified of the fracture on 12/8/14 she did talk to some of the staff to verify the resident did not have any falls. When interviewed on 12/29/14 at 10:50 a.m., the Director of Nursing indicated there had been no incident report and she had not been notified of the swelling and pain of the resident's right foot on 12/6/14 or 12/7/14. The Director of Nursing indicated when she spoke with staff Nurses and CNAs on Monday 12/8/14 she asked them if the resident had any falls and they indicated she did not. The Director of Nursing indicated the resident required the assistance of two staff members for transfers. The Director of Nursing also indicated the resident had a history of fighting with staff with transfers and care. The Director of Nursing indicated she was not working on 12/6/14 (Saturday) or 12/7/14 (Sunday) and was not informed of the resident's new onset of leg pain, swelling and redness until 12/8/14.			

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	When interviewed on 12/29/14 at 12:15 p.m., the Director of Nursing indicated all injuries including bruises, skin tears or any injuries that could not be explained were to be investigated. When interviewed on 12/29/14 at 11:20 a.m., the Social Service Director indicated the resident did have behaviors and would be physically aggressive with staff when they were providing care for the resident. When interviewed on 12/29/14 at 12:40 p.m., the facility Administrator indicated all injuries of unknown origin were to be investigated. The Administrator indicated the facility should have investigated the resident's pain, swelling, and redness to the leg earlier when first noted by staff since the resident was dependent on staff for care and had a history of being aggressive with care. The facility policy titled "Abuse/Neglect Investigations" was reviewed on 12/29/14 at 1:20 p.m. The policy had a revised date of August 2008. The Director of Nursing provided the policy and indicated the policy was current. The policy indicated all reports and/or allegations of abuse, neglect, and injuries of unknown source were to be promptly and thoroughly investigated by facility			

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	management. The policy indicated the investigations should include interviews with staff members (on all shifts) who had contact with the resident during the alleged incident. This Federal tag relates to Complaint IN00161017. 3.1-28(a)			